S. 438. A bill to amend the Federal Food, Drug, and Cosmetic Act to clarify the Food and Drug Administration's jurisdiction over certain tobacco products, and to protect jobs and small businesses involved in the sale, manufacturing and distribution of traditional and premium cigars; to the Committee on Health, Education, Labor, and Pensions.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Ms. ERNST (for herself, Mr. GRASSLEY, and Mrs. FISCHER):

S. Res. 71. A resolution expressing the sense of the Senate that aliens convicted of drunk driving offenses qualify as a public safety threat for the purposes of immigration enforcement; to the Committee on the Judiciary.

By Mr. COTTON (for himself, Mr. CRUZ, Mr. RUBIO, Mr. CORNYN, Mr. HAWLEY, Mr. CRAMER, Mr. TILLIS, Mr. BOOZMAN, Mrs. HYDE-SMITH, Mr. SASSE, Mr. MARSHALL, Mr. DAINES, Mr. ROUNDS, Mr. YOUNG, Mr. BARRASSO, Mrs. BLACKBURN, Mr. SULLIVAN, Mr. TUBERVILLE, Mr. BLUNT, Mr. THUNE, Ms. LUMMIS, Mr. INHOFE, Mr. HOEVEN, Mr. HAGERTY, Mr. LANKFORD, and Mr. CRAPO):

S. Res. 72. A resolution opposing the lifting of sanctions imposed with respect to Iran without addressing the full scope of Iran's malign activities, including its nuclear program, ballistic and cruise missile capabilities, weapons proliferation, support for terrorism, hostage-taking, gross human rights violations, and other destabilizing activities; to the Committee on Banking, Housing, and Urban Affairs.

By Ms. ROSEN (for herself and Mr. RUBIO):

S. Res. 73. A resolution reaffirming the commitment to media diversity and pledging to work with media entities and diverse stakeholders to develop common ground solutions to eliminate barriers to media diversity; to the Committee on Commerce, Science, and Transportation.

By Mr. BROWN (for himself, Mr. BARRASSO, Mr. BLUMENTHAL, Mr. SCOTT of South Carolina, Ms. KLOBUCHAR, Mr. WICKER, Mr. MARKEY, and Mr. BOOKER):

S. Res. 74. A resolution designating February 28, 2021, as ''Rare Disease Day''; considered and agreed to.

By Mr. BOOKER (for himself, Mr. SCOTT of South Carolina, Mr. DURBIN, Mr. BLUNT, Ms. HASSAN, Mr. TILLIS, Ms. CORTEZ MASTO, Mr. CRAPO, Mr. MERKLEY, Mr. GRASSLEY, Mr. WYDEN, Mr. RISCH, Ms. SMITH, Mr. CRAMER, Mr. MARKEY, Mr. WICKER, Ms. HIRONO, Mr. SULLIVAN, Mr. BROWN, Mr. SHELBY, Mr. VAN HOLLEN, Mr. RUBIO, Mr. MENENDEZ, Mr. SCOTT of Florida, Ms. DUCKWORTH, Mr. PORTMAN, Mr. BLUMENTHAL, Mr. HAGERTY, Mr. COONS, Mr. LANKFORD, Ms. BALDWIN, Mr. BRAUN, Mrs. MURRAY, Mr. GRAHAM, Mr. WARNER, Ms. ERNST, Mr. KAINE, Mr. BURR, Mrs. FEINSTEIN, Mr. YOUNG, Ms. ROSEN, Mr. MURPHY, Ms. SINEMA, Mrs. SHAHEEN, Mr. WHITEHOUSE, Mr. SCHATZ, Mrs. GILLIBRAND, Ms. KLOBUCHAR, Mr. KING, Mr. BENNET, Ms. WARREN, Mr. OSSOFF, Mr. HEINRICH, Mr. SANDERS, Mr. CARPER, Mr. CASEY, Mr. REED, Mr. CARDIN, Ms. CANTWELL, Mr. LUJÁN, Mrs. HYDE-SMITH, Mrs. BLACKBURN, and Mr. HOEVEN):

S. Res. 75. A resolution celebrating Black History Month; considered and agreed to.

ADDITIONAL COSPONSORS

S. 25

At the request of Mrs. BLACKBURN, the name of the Senator from Louisiana (Mr. KENNEDY) was added as a cosponsor of S. 25, a bill to restrict certain Federal grants for States that grant driver licenses to illegal immigrants and fail to share information about criminal aliens with the Federal Government.

S. 51

At the request of Mr. CARPER, the name of the Senator from New Mexico (Mr. LUJÁN) was added as a cosponsor of S. 51, a bill to provide for the admission of the State of Washington, D.C. into the Union.

S. 134

At the request of Mr. MORAN, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 134, a bill to direct the Secretary of Veterans Affairs to carry out a retraining assistance program for unemployed veterans, and for other purposes.

At the request of Mr. TESTER, the name of the Senator from Delaware (Mr. COONS) was added as a cosponsor of S. 134, supra.

S. 158

At the request of Mr. CARDIN, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 158, a bill to promote international efforts in combating corruption, kleptocracy, and illicit finance by foreign officials and other foreign persons, including through a new anti-corruption action fund, and for other purposes.

S. 200

At the request of Mrs. MURRAY, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 200, a bill to provide State and local workforce and career and technical education systems the support to respond to the COVID–19 national emergency.

S. 283

At the request of Mr. MARKEY, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 283, a bill to establish a National Climate Bank.

S. 313

At the request of Mr. DURBIN, the name of the Senator from Maine (Mr. KING) was added as a cosponsor of S. 313, a bill to amend the Food and Nutrition Act of 2008 to expand online benefit redemption options under the supplemental nutrition assistance program, and for other purposes.

S. 347

At the request of Ms. SMITH, the names of the Senator from New Hampshire (Mrs. SHAHEEN) and the Senator from Nevada (Ms. ROSEN) were added as cosponsors of S. 347, a bill to improve the collection and review of maternal health data to address maternal mortality, serve maternal morbidity, and other adverse maternal health outcomes.

S. 361

At the request of Mr. CRUZ, the name of the Senator from Utah (Mr. LEE) was added as a cosponsor of S. 361, a bill to establish a 90-day limit to file a petition for judicial review of a permit, license, or approval for a highway or public transportation project, and for other purposes.

S. 395

At the request of Mr. MERKLEY, the names of the Senator from Minnesota (Ms. SMITH) and the Senator from Massachusetts (Ms. WARREN) were added as cosponsors of S. 395, a bill to amend the Internal Revenue Code of 1986 to extend certain tax credits related to electric cars, and for other purposes.

S. RES. 43

At the request of Mr. MARKEY, the name of the Senator from California (Mr. PADILLA) was added as a cosponsor of S. Res. 43, a resolution recognizing the duty of the Federal Government to implement an agenda to Transform, Heal, and Renew by Investing in a Vibrant Economy (' THRIVE'').

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTION

By Mr. THUNE (for himself, Ms. STABENOW, Mrs. FISCHER, and Mr. WARNER):

S. 402. A bill to amend the Bipartisan Congressional Trade Priorities and Accountability Act of 2015 to include a trade negotiating objecting relating to addressing the security of the global communications infrastructure; to the Committee on Finance.

Mr. THUNE. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 402

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Network Security Trade Act of 2021''.

SEC. 2. TRADE NEGOTIATING OBJECTIVE RELATING TO SECURITY OF COMMUNICATIONS NETWORKS.

Section 102(a) of the Bipartisan Congressional Trade Priorities and Accountability Act of 2015 (19 U.S.C. 4201(a)) is amended—

(1) in paragraph (14), by striking ''; and'' and inserting a semicolon;

(2) in paragraph (15), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(16) to ensure that the equipment and technology that create the global communications infrastructure are not compromised by addressing—

''(A) barriers to the security of communications networks and supply chains; and

''(B) unfair trade practices of suppliers of communications equipment that are owned, controlled, or supported by a foreign government.''.

By Mr. DURBIN (for himself, Ms. DUCKWORTH, Mrs. SHAHEEN, Mr. BROWN, Ms. STABENOW, Mr. BLUMENTHAL, Ms. KLOBUCHAR, Ms. SMITH, Mr. VAN HOLLEN, and Mr. SANDERS):

S. 411. A bill to improve Federal efforts with respect to the prevention of maternal mortality, and for other purposes; to the Committee on Finance.

Mr. THUNE. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 411

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Mothers and Offspring Mortality and Morbidity Awareness Act'' or the ''MOMMA's Act''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) Every year, across the United States, nearly 4,000,000 women give birth, about 700 women suffer fatal complications during pregnancy, while giving birth or during the postpartum period, and about 70,000 women suffer near-fatal, partum-related complications.

(2) The maternal mortality rate is often used as a proxy to measure the overall health of a population. While the infant mortality rate in the United States has reached its lowest point, the risk of death for women in the United States during pregnancy, childbirth, or the postpartum period is higher than such risk in many other high-income countries. The estimated maternal mortality rate (deaths per 100,000 live births) for the 48 contiguous States and Washington, D.C. increased from 14.5 percent in 2000 to 17.3 in 2017. The United States is the only industrialized nation with a rising maternal mortality rate.

(3) The National Vital Statistics System of the Centers for Disease Control and Prevention has found that in 2018, there were 17.4 maternal deaths for every 100,000 live births in the United States. This ratio is more than double that of most other high-income countries.

(4) It is estimated that more than 60 percent of maternal deaths in the United States are preventable.

(5) According to the Centers for Disease Control and Prevention, the maternal mortality rate varies drastically for women by race and ethnicity. There are about 13 deaths per 100,000 live births for White women, 40.8 deaths per 100,000 live births for non-Hispanic Black women, and 29.7 deaths per 100,000 live births for American Indian/Alaskan Native women. While maternal mortality disparately impacts Black women, this urgent public health crisis traverses race, ethnicity, socioeconomic status, educational background, and geography.

(6) In the United States, non-Hispanic Black women are about 3 times more likely to die from causes related to pregnancy and childbirth compared to non-Hispanic White women, which is one of the most disconcerting racial disparities in public health. This disparity widens in certain cities and States across the country.

(7) According to the National Center for Health Statistics of the Centers for Disease Control and Prevention, the maternal mortality rate heightens with age, as women 40 and older die at a rate of 81.9 per 100,000 births compared to 10.6 per 100,000 for women under 25. This translates to women over 40 being 7.7 times more likely to die compared to their counterparts under 25 years of age.

(8) The COVID–19 pandemic risks exacerbating the maternal health crisis. A recent study of the Centers for Disease Control and Prevention suggests that pregnant women are at a significantly higher risk for severe outcomes, including death, from COVID–19 as compared to non-pregnant women. The COVID–19 pandemic has also decreased access to prenatal and postpartum care.

(9) The findings described in paragraphs (1) through (8) are of major concern to researchers, academics, members of the business community, and providers across the obstetric continuum represented by organizations such as—

(A) the American College of Nurse-Midwives;

(B) the American College of Obstetricians and Gynecologists;

(C) the American Medical Association;

(D) the Association of Women's Health, Obstetric and Neonatal Nurses;

(E) the Black Mamas Matter Alliance;

(F) the Black Women's Health Imperative;

(G) the California Maternal Quality Care Collaborative;

(H) EverThrive Illinois;

(I) the Illinois Perinatal Quality Collaborative;

(J) the March of Dimes;

(K) the National Association of Certified Professional Midwives;

(L) the National Birth Equity Collaborative;

(M) the National Partnership for Women & Families;

(N) the National Polycystic Ovary Syndrome Association;

(O) the Preeclampsia Foundation;

(P) the Society for Maternal-Fetal Medicine; and

(Q) the What To Expect Project.

(10) Hemorrhage, cardiovascular and coronary conditions, cardiomyopathy, infection or sepsis, embolism, mental health conditions (including substance use disorder), hypertensive disorders, stroke and cerebrovascular accidents, and anesthesia complications are the predominant medical causes of maternal-related deaths and complications. Most of these conditions are largely preventable or manageable. Even when these conditions are not preventable, mortality and morbidity may be prevented when conditions are diagnosed and treated in a timely manner.

(11) According to a study published by the Journal of Perinatal Education, doula-assisted mothers are 4 times less likely to have a low-birthweight baby, 2 times less likely to experience a birth complication involving themselves or their baby, and significantly more likely to initiate breastfeeding. Doula care has also been shown to produce cost savings resulting in part from reduced rates of cesarean and pre-term births.

(12) Intimate partner violence is one of the leading causes of maternal death, and women are more likely to experience intimate partner violence during pregnancy than at any other time in their lives. It is also more dangerous than pregnancy. Intimate partner violence during pregnancy and postpartum crosses every demographic and has been exacerbated by the COVID–19 pandemic.

(13) Oral health is an important part of perinatal health. Reducing bacteria in a woman's mouth during pregnancy can significantly reduce her risk of developing oral diseases and spreading decay-causing bacteria to her baby. Moreover, some evidence suggests that women with periodontal disease during pregnancy could be at greater risk for poor birth outcomes, such as preeclampsia, pre-term birth, and low-birth weight. Furthermore, a woman's oral health during pregnancy is a good predictor of her newborn's oral health, and since mothers can unintentionally spread oral bacteria to their babies, putting their children at higher risk for tooth decay, prevention efforts should happen even before children are born, as a matter of pre-pregnancy health and prenatal care during pregnancy.

(14) In the United States, death reporting and analysis is a State function rather than a Federal process. States report all deaths—including maternal deaths—on a semi-voluntary basis, without standardization across States. While the Centers for Disease Control and Prevention has the capacity and system for collecting death-related data based on death certificates, these data are not sufficiently reported by States in an organized and standard format across States such that the Centers for Disease Control and Prevention is able to identify causes of maternal death and best practices for the prevention of such death.

(15) Vital statistics systems often underestimate maternal mortality and are insufficient data sources from which to derive a full scope of medical and social determinant factors contributing to maternal deaths, such as intimate partner violence. While the addition of pregnancy checkboxes on death certificates since 2003 have likely improved States' abilities to identify pregnancy-related deaths, they are not generally completed by obstetric providers or persons trained to recognize pregnancy-related mortality. Thus, these vital forms may be missing information or may capture inconsistent data. Due to varying maternal mortality-related analyses, lack of reliability, and granularity in data, current maternal mortality informatics do not fully encapsulate the myriad medical and socially determinant factors that contribute to such high maternal mortality rates within the United States compared to other developed nations. Lack of standardization of data and data sharing across States and between Federal entities, health networks, and research institutions keep the Nation in the dark about ways to prevent maternal deaths.

(16) Having reliable and valid State data aggregated at the Federal level are critical to the Nation's ability to quell surges in maternal death and imperative for researchers to identify long-lasting interventions.

(17) Leaders in maternal wellness highly recommend that maternal deaths and cases of maternal morbidity, including complications that result in chronic illness and future increased risk of death, be investigated at the State level first, and that standardized, streamlined, de-identified data regarding maternal deaths be sent annually to the Centers for Disease Control and Prevention. Such data standardization and collection would be similar in operation and effect to the National Program of Cancer Registries of the Centers for Disease Control and Prevention and akin to the Confidential Enquiry in Maternal Deaths Programme in the United Kingdom. Such a maternal mortalities and morbidities registry and surveillance system would help providers, academicians, lawmakers, and the public to address questions concerning the types of, causes of, and best practices to thwart, maternal mortality and morbidity.

(18) The United Nations' Millennium Development Goal 5a aimed to reduce by 75 percent, between 1990 and 2015, the maternal mortality rate, yet this metric has not been achieved. In fact, the maternal mortality rate in the United States has been estimated to have more than doubled between 2000 and 2014.

(19) Many States have struggled to establish or maintain Maternal Mortality Review

Committees (referred to in this section as ''MMRC''). On the State level, MMRCs have lagged because States have not had the resources to mount local reviews. State-level reviews are necessary as only the State departments of health have the authority to request medical records, autopsy reports, and police reports critical to the function of the MMRC.

(20) The United States has no comparable, coordinated Federal process by which to review cases of maternal mortality, systems failures, or best practices. Many States have active MMRCs and leverage their work to impact maternal wellness. For example, the State of California has worked extensively with their State health departments, health and hospital systems, and research collaborative organizations, including the California Maternal Quality Care Collaborative and the Alliance for Innovation on Maternal Health, to establish MMRCs, wherein such State has determined the most prevalent causes of maternal mortality and recorded and shared data with providers and researchers, who have developed and implemented safety bundles and care protocols related to preeclampsia, maternal hemorrhage, peripartum cardiomyopathy, and the like. In this way, the State of California has been able to leverage its maternal mortality review board system, generate data, and apply those data to effect changes in maternal care-related protocol. To date, the State of California has reduced its maternal mortality rate, which is now comparable to the low rates of the United Kingdom.

(21) Hospitals and health systems across the United States lack standardization of emergency obstetric protocols before, during, and after delivery. Consequently, many providers are delayed in recognizing critical signs indicating maternal distress that quickly escalate into fatal or near-fatal incidences. Moreover, any attempt to address an obstetric emergency that does not consider both clinical and public health approaches falls woefully under the mark of excellent care delivery. State-based perinatal quality collaboratives, or entities participating in the Alliance for Innovation on Maternal Health (AIM), have formed obstetric protocols, tool kits, and other resources to improve system care and response as they relate to maternal complications and warning signs for such conditions as maternal hemorrhage, hypertension, and preeclampsia. These perinatal quality collaboratives serve an important role in providing infrastructure that supports quality improvement efforts addressing obstetric care and outcomes. State-based perinatal quality collaboratives partner with hospitals, physicians, nurses, patients, public health, and other stakeholders to provide opportunities for collaborative learning, rapid response data, and quality improvement science support to achieve systems-level change.

(22) The Centers for Disease Control and Prevention reports that nearly half of all maternal deaths occur in the immediate postpartum period—the 42 days following a pregnancy—whereas more than one-third of maternal deaths occur while a person is still pregnant. Further, 21 percent of maternal deaths occur between 1 and 6 weeks postpartum, and 12 percent of maternal deaths occur during the remaining portion of the postpartum year. Yet, for women eligible for the Medicaid program on the basis of pregnancy, such Medicaid coverage lapses at the end of the month on which the 60th postpartum day lands.

(23) The experience of serious traumatic events, such as being exposed to domestic violence, substance use disorder, or pervasive and systematic racism, can over-activate the body's stress-response system. Known as toxic stress, the repetition of high-doses of cortisol to the brain, can harm healthy neurological development and other body systems, which can have cascading physical and mental health consequences, as documented in the Adverse Childhood Experiences study of the Centers for Disease Control and Prevention.

(24) A growing body of evidence-based research has shown the correlation between the stress associated with systematic racism and one's birthing outcomes. The undue stress of sex and race discrimination paired with institutional racism has been demonstrated to contribute to a higher risk of maternal mortality, irrespective of one's gestational age, maternal age, socioeconomic status, educational level, or individual-level health risk factors, including poverty, limited access to prenatal care, and poor physical and mental health (although these are not nominal factors). Black women remain the most at risk for pregnancy-associated or pregnancy-related causes of death. When it comes to preeclampsia, for example, for which obesity is a risk factor, Black women of normal weight remain at a higher at risk of dying during the perinatal period compared to non-Black obese women.

(25) The rising maternal mortality rate in the United States is driven predominantly by the disproportionately high rates of Black maternal mortality.

(26) Compared to women from other racial and ethnic demographics, Black women across the socioeconomic spectrum experience prolonged, unrelenting stress related to systematic racial and gender discrimination, contributing to higher rates of maternal mortality, giving birth to low-weight babies, and experiencing pre-term birth. Racism is a risk-factor for these aforementioned experiences. This cumulative stress, called weathering, often extends across the life course and is situated in everyday spaces where Black women establish livelihood. Systematic racism, structural barriers, lack of access to care, lack of access to nutritious food, and social determinants of health exacerbate Black women's likelihood to experience poor or fatal birthing outcomes, but do not fully account for the great disparity.

(27) Black women are twice as likely to experience postpartum depression, and disproportionately higher rates of preeclampsia compared to White women.

(28) Racism is deeply ingrained in United States systems, including in health care delivery systems between patients and providers, often resulting in disparate treatment for pain, irreverence for cultural norms with respect to health, and dismissiveness. However, the provider pool is not primed with many people of color, nor are providers (whether maternity care clinicians or maternity care support personnel) consistently required to undergo implicit bias, cultural competency, respectful care practices, or empathy training on a consistent, on-going basis.

(29) Not all people who have been pregnant or given birth identify as being a ''woman''. The terms ''birthing people'' or ''birthing persons'' are also used to describe pregnant and postpartum people.

SEC. 3. IMPROVING FEDERAL EFFORTS WITH RESPECT TO PREVENTION OF MATERNAL MORTALITY.

(a) TECHNICAL ASSISTANCE FOR STATES WITH RESPECT TO REPORTING MATERNAL MORTALITY.—Not later than one year after the date of enactment of this Act, the Director of the Centers for Disease Control and Prevention (referred to in this section as the ''Director''), in consultation with the Administrator of the Health Resources and Services Administration, shall provide technical assistance to States that elect to report comprehensive data on maternal mortality and factors relating to such mortality (including oral and mental health), intimate partner violence, and breastfeeding health information, for the purpose of encouraging uniformity in the reporting of such data and to encourage the sharing of such data among the respective States.

(b) BEST PRACTICES RELATING TO PREVENTION OF MATERNAL MORTALITY.—

(1) IN GENERAL.—Not later than one year after the date of enactment of this Act—

(A) the Director, in consultation with relevant patient and provider groups, shall issue best practices to State maternal mortality review committees on how best to identify and review maternal mortality cases, taking into account any data made available by States relating to maternal mortality, including data on oral, mental, and breastfeeding health, and utilization of any emergency services; and

(B) the Director, working in collaboration with the Health Resources and Services Administration, shall issue best practices to hospitals, State professional society groups, and perinatal quality collaboratives on how best to prevent maternal mortality.

(2) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this subsection, there is authorized to be appropriated $5,000,000 for each of fiscal years 2021 through 2025.

(c) ALLIANCE FOR INNOVATION ON MATERNAL HEALTH GRANT PROGRAM.—

(1) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this subsection as the ''Secretary''), acting through the Associate Administrator of the Maternal and Child Health Bureau of the Health Resources and Services Administration, shall establish a grant program to be known as the Alliance for Innovation on Maternal Health Grant Program (referred to in this subsection as ''AIM'') under which the Secretary shall award grants to eligible entities for the purpose of—

(A) directing widespread adoption and implementation of maternal safety bundles through collaborative State-based teams; and

(B) collecting and analyzing process, structure, and outcome data to drive continuous improvement in the implementation of such safety bundles by such State-based teams with the ultimate goal of eliminating preventable maternal mortality and severe maternal morbidity in the United States.

(2) ELIGIBLE ENTITIES.—In order to be eligible for a grant under paragraph (1), an entity shall—

(A) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and

(B) demonstrate in such application that the entity is an interdisciplinary, multi-stakeholder, national organization with a national data-driven maternal safety and quality improvement initiative based on implementation approaches that have been proven to improve maternal safety and outcomes in the United States.

(3) USE OF FUNDS.—An eligible entity that receives a grant under paragraph (1) shall use such grant funds—

(A) to develop and implement, through a robust, multi-stakeholder process, maternal safety bundles to assist States, perinatal quality collaboratives, and health care systems in aligning national, State, and hospital-level quality improvement efforts to improve maternal health outcomes, specifically the reduction of maternal mortality and severe maternal morbidity;

(B) to ensure, in developing and implementing maternal safety bundles under subparagraph (A), that such maternal safety bundles—

(i) satisfy the quality improvement needs of a State, perinatal quality collaborative, or health care system by factoring in the results and findings of relevant data reviews, such as reviews conducted by a State maternal mortality review committee; and

(ii) address topics which may include—

(I) information on evidence-based practices to improve the quality and safety of maternal health care in hospitals and other health care settings of a State or health care system, including by addressing topics commonly associated with health complications or risks related to prenatal care, labor care, birthing, and postpartum care;

(II) best practices for improving maternal health care based on data findings and reviews conducted by a State maternal mortality review committee that address topics of relevance to common complications or health risks related to prenatal care, labor care, birthing, and postpartum care;

(III) information on addressing determinants of health that impact maternal health outcomes for women before, during, and after pregnancy;

(IV) obstetric hemorrhage;

(V) obstetric and postpartum care for women with substance use disorders, including opioid use disorder;

(VI) maternal cardiovascular system;

(VII) maternal mental health;

(VIII) postpartum care basics for maternal safety;

(IX) reduction of peripartum racial and ethnic disparities;

(X) reduction of primary caesarean birth;

(XI) severe hypertension in pregnancy;

(XII) severe maternal morbidity reviews;

(XIII) support after a severe maternal morbidity event;

(XIV) thromboembolism;

(XV) optimization of support for breastfeeding;

(XVI) maternal oral health; and

(XVII) Intimate partner violence; and

(C) to provide ongoing technical assistance at the national and State levels to support implementation of maternal safety bundles under subparagraph (A).

(4) MATERNAL SAFETY BUNDLE DEFINED.—For purposes of this subsection, the term ''maternal safety bundle'' means standardized, evidence-informed processes for maternal health care.

(5) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this subsection, there is authorized to be appropriated $10,000,000 for each of fiscal years 2021 through 2025.

(d) FUNDING FOR STATE-BASED PERINATAL QUALITY COLLABORATIVES DEVELOPMENT AND SUSTAINABILITY.—

(1) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this subsection as the ''Secretary''), acting through the Division of Reproductive Health of the Centers for Disease Control and Prevention, shall establish a grant program to be known as the State-Based Perinatal Quality Collaborative grant program under which the Secretary awards grants to eligible entities for the purpose of development and sustainability of perinatal quality collaboratives in every State, the District of Columbia, and eligible territories, in order to measurably improve perinatal care and perinatal health outcomes for pregnant and postpartum women and their infants.

(2) GRANT AMOUNTS.—Grants awarded under this subsection shall be in amounts not to exceed $250,000 per year, for the duration of the grant period.

(3) STATE-BASED PERINATAL QUALITY COLLABORATIVE DEFINED.—For purposes of this subsection, the term ''State-based perinatal quality collaborative'' means a network of teams that—

(A) is multidisciplinary in nature and includes the full range of perinatal and maternity care providers;

(B) works to improve measurable outcomes for maternal and infant health by advancing evidence-informed clinical practices using quality improvement principles;

(C) works with hospital-based or outpatient facility-based clinical teams, experts, and stakeholders, including patients and families, to spread best practices and optimize resources to improve perinatal care and outcomes;

(D) employs strategies that include the use of the collaborative learning model to provide opportunities for hospitals and clinical teams to collaborate on improvement strategies, rapid-response data to provide timely feedback to hospital and other clinical teams to track progress, and quality improvement science to provide support and coaching to hospital and clinical teams;

(E) has the goal of improving population-level outcomes in maternal and infant health; and

(F) has the goal of improving outcomes of all birthing people, through the coordination, integration, and collaboration across birth settings.

(4) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this subsection, there is authorized to be appropriated $14,000,000 per year for each of fiscal years 2021 through 2025.

(e) EXPANSION OF MEDICAID AND CHIP COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—

(1) REQUIRING COVERAGE OF ORAL HEALTH SERVICES FOR PREGNANT AND POSTPARTUM WOMEN.—

(A) MEDICAID.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(i) in subsection (a)(4)—

(I) by striking ''; and (D)'' and inserting ''; (D)''; and

(II) by inserting ''; and (E) oral health services for pregnant and postpartum women (as defined in subsection (hh))'' after ''subsection (bb))''; and

(ii) by adding at the end the following new subsection:

''(hh) ORAL HEALTH SERVICES FOR PREGNANT AND POSTPARTUM WOMEN.—

''(1) IN GENERAL.—For purposes of this title, the term 'oral health services for pregnant and postpartum women' means dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions that are furnished to a woman during pregnancy (or during the 1-year period beginning on the last day of the pregnancy).

''(2) COVERAGE REQUIREMENTS.—To satisfy the requirement to provide oral health services for pregnant and postpartum women, a State shall, at a minimum, provide coverage for preventive, diagnostic, periodontal, and restorative care consistent with recommendations for perinatal oral health care and dental care during pregnancy from the American Academy of Pediatric Dentistry and the American College of Obstetricians and Gynecologists.''.

(B) CHIP.—Section 2103(c)(5)(A) of the Social Security Act (42 U.S.C. 1397cc(c)(5)(A)) is amended by inserting ''or a targeted low-income pregnant woman'' after ''targeted low-income child''.

(2) EXTENDING MEDICAID COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in subsection (e)—

(i) in paragraph (5)—

(I) by inserting ''(including oral health services for pregnant and postpartum women (as defined in section 1905(hh)))'' after ''postpartum medical assistance under the plan''; and

(II) by striking ''60-day'' and inserting ''1-year''; and

(ii) in paragraph (6), by striking ''60-day'' and inserting ''1-year''; and

(B) in subsection (l)(1)(A), by striking ''60-day'' and inserting ''1-year''.

(3) EXTENDING MEDICAID COVERAGE FOR LAWFUL RESIDENTS.—Section 1903(v)(4)(A)(i) of the Social Security Act (42 U.S.C. 1396b(v)(4)(A)(i)) is amended by striking ''60-day'' and inserting ''1-year''.

(4) EXTENDING CHIP COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—Section 2112(d)(2)(A) of the Social Security Act (42 U.S.C. 1397ll(d)(2)(A)) is amended by striking ''60-day'' and inserting ''1-year''.

(5) MAINTENANCE OF EFFORT.—

(A) MEDICAID.—Section 1902(l) of the Social Security Act (42 U.S.C. 1396a(l)) is amended by adding at the end the following new paragraph:

''(5) During the period that begins on the date of enactment of this paragraph and ends on the date that is five years after such date of enactment, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect, with respect to women who are eligible for medical assistance under the State plan or under a waiver of such plan on the basis of being pregnant or having been pregnant, eligibility standards, methodologies, or procedures under the State plan or waiver that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan or waiver that are in effect on the date of enactment of this paragraph.''.

(B) CHIP.—Section 2105(d) of the Social Security Act (42 U.S.C. 1397ee(d)) is amended by adding at the end the following new paragraph:

''(4) IN ELIGIBILITY STANDARDS FOR TARGETED LOW-INCOME PREGNANT WOMEN.—During the period that begins on the date of enactment of this paragraph and ends on the date that is five years after such date of enactment, as a condition of receiving payments under subsection (a) and section 1903(a), a State that elects to provide assistance to women on the basis of being pregnant (including pregnancy-related assistance provided to targeted low-income pregnant women (as defined in section 2112(d)), pregnancy-related assistance provided to women who are eligible for such assistance through application of section 1902(v)(4)(A)(i) under section 2107(e)(1), or any other assistance under the State child health plan (or a waiver of such plan) which is provided to women on the basis of being pregnant) shall not have in effect, with respect to such women, eligibility standards, methodologies, or procedures under such plan (or waiver) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) that are in effect on the date of enactment of this paragraph.''.

(6) INFORMATION ON BENEFITS.—The Secretary of Health and Human Services shall make publicly available on the Internet website of the Department of Health and Human Services, information regarding benefits available to pregnant and postpartum women and under the Medicaid program and the Children's Health Insurance Program, including information on—

(A) benefits that States are required to provide to pregnant and postpartum women under such programs;

(B) optional benefits that States may provide to pregnant and postpartum women under such programs; and

(C) the availability of different kinds of benefits for pregnant and postpartum women, including oral health and mental health benefits, under such programs.

(7) FEDERAL FUNDING FOR COST OF EXTENDED MEDICAID AND CHIP COVERAGE FOR POSTPARTUM WOMEN.—

(A) MEDICAID.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by paragraph (1), is further amended—

(i) in subsection (b), by striking ''and (ff)'' and inserting ''(aa), and (ii)''; and

(ii) by adding at the end the following:

''(b) INCREASED FMAP FOR EXTENDED MEDICAL ASSISTANCE FOR POSTPARTUM WOMEN.—Notwithstanding subsection (b), the Federal medical assistance percentage for a State, with respect to amounts expended by such State for medical assistance for a woman who is eligible for such assistance on the basis of being pregnant or having been pregnant that is provided during the 305-day period that begins on the 60th day after the last day of her pregnancy (including any such assistance provided during the month in which such period ends), shall be equal to—

''(1) 100 percent for the first 20 calendar quarters during which this subsection is in effect; and

''(2) 90 percent for calendar quarters thereafter.''.

(B) CHIP.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

''(12) ENHANCED PAYMENT FOR EXTENDED ASSISTANCE PROVIDED TO PREGNANT WOMEN.—Notwithstanding subsection (b), the enhanced FMAP, with respect to payments under subsection (a) for expenditures under the State child health plan (or a waiver of such plan) for assistance provided under the plan (or waiver) to a woman who is eligible for such assistance on the basis of being pregnant (including pregnancy-related assistance provided to a targeted low-income pregnant woman (as defined in section 2112(d)), pregnancy-related assistance provided to a woman who is eligible for such assistance through application of section 1902(v)(4)(A)(i) under section 2107(e)(1), or any other assistance under the plan (or waiver) provided to a woman who is eligible for such assistance on the basis of being pregnant) during the 305-day period that begins on the 60th day after the last day of her pregnancy (including any such assistance provided during the month in which such period ends), shall be equal to—

''(A) 100 percent for the first 20 calendar quarters during which this paragraph is in effect; and

''(B) 90 percent for calendar quarters thereafter.''.

(8) GUIDANCE ON STATE OPTIONS FOR MEDICAID COVERAGE OF DOULA SERVICES.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall issue guidance for the States concerning options for Medicaid coverage and payment for support services provided by doulas.

(9) EFFECTIVE DATE.—

(A) IN GENERAL.—Subject to subparagraph (B), the amendments made by this subsection shall take effect on the first day of the first calendar quarter that begins on or after the date that is one year after the date of enactment of this Act.

(B) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act or a State child health plan under title XXI of such Act that the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet any requirement imposed by amendments made by this subsection, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

(f) REGIONAL CENTERS OF EXCELLENCE.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following new section:

''SEC. 399V–7. REGIONAL CENTERS OF EXCELLENCE ADDRESSING IMPLICIT BIAS AND CULTURAL COMPETENCY IN PATIENT-PROVIDER INTERACTIONS EDUCATION.

''(a) IN GENERAL.—Not later than one year after the date of enactment of this section, the Secretary, in consultation with such other agency heads as the Secretary determines appropriate, shall award cooperative agreements for the establishment or support of regional centers of excellence addressing implicit bias, cultural competency, and respectful care practices in patient-provider interactions education for the purpose of enhancing and improving how health care professionals are educated in implicit bias and delivering culturally competent health care.

''(b) ELIGIBILITY.—To be eligible to receive a cooperative agreement under subsection (a), an entity shall—

''(1) be a public or other nonprofit entity specified by the Secretary that provides educational and training opportunities for students and health care professionals, which may be a health system, teaching hospital, community health center, medical school, school of public health, school of nursing, dental school, social work school, school of professional psychology, or any other health professional school or program at an institution of higher education (as defined in section 101 of the Higher Education Act of 1965) focused on the prevention, treatment, or recovery of health conditions that contribute to maternal mortality and the prevention of maternal mortality and severe maternal morbidity;

''(2) demonstrate community engagement and participation, such as through partnerships with home visiting and case management programs;

''(3) demonstrate engagement with groups engaged in the implementation of health care professional training in implicit bias and delivering culturally competent care, such as departments of public health, perinatal quality collaboratives, hospital systems, and health care professional groups, in order to obtain input on resources needed for effective implementation strategies; and

''(4) provide to the Secretary such information, at such time and in such manner, as the Secretary may require.

''(c) DIVERSITY.—In awarding a cooperative agreement under subsection (a), the Secretary shall take into account any regional differences among eligible entities and make an effort to ensure geographic diversity among award recipients.

''(d) DISSEMINATION OF INFORMATION.—

''(1) PUBLIC AVAILABILITY.—The Secretary shall make publicly available on the internet website of the Department of Health and Human Services information submitted to the Secretary under subsection (b)(3).

''(2) EVALUATION.—The Secretary shall evaluate each regional center of excellence established or supported pursuant to subsection (a) and disseminate the findings resulting from each such evaluation to the appropriate public and private entities.

''(3) DISTRIBUTION.—The Secretary shall share evaluations and overall findings with State departments of health and other relevant State level offices to inform State and local best practices.

''(e) MATERNAL MORTALITY DEFINED.—In this section, the term 'maternal mortality' means death of a woman that occurs during pregnancy or within the one-year period following the end of such pregnancy.

''(f) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there is authorized to be appropriated $5,000,000 for each of fiscal years 2021 through 2025.''.

(g) SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN.—Section 17(d)(3)(A)(ii) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(d)(3)(A)(ii)) is amended—

(1) by striking the clause designation and heading and all that follows through ''A State'' and inserting the following:

''(ii) WOMEN.—

''(I) BREASTFEEDING WOMEN.—A State'';

(2) in subclause (I) (as so designated), by striking ''1 year'' and all that follows through ''earlier'' and inserting ''2 years postpartum''; and

(3) by adding at the end the following:

''(II) POSTPARTUM WOMEN.—A State may elect to certify a postpartum woman for a period of 2 years.''.

(h) DEFINITIONS.—In this section:

(1) MATERNAL MORTALITY.—The term ''maternal mortality'' means death of a woman that occurs during pregnancy or within the one-year period following the end of such pregnancy.

(2) PREGNANCY RELATED DEATH.—The term ''pregnancy related death'' includes the death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

(3) SEVERE MATERNAL MORBIDITY.—The term ''severe maternal morbidity'' includes unexpected outcomes of labor and delivery that result in significant short-term or long-term consequences to a woman's health.

SEC. 4. INCREASING EXCISE TAXES ON CIGARETTES AND ESTABLISHING EXCISE TAX EQUITY AMONG ALL TOBACCO PRODUCT TAX RATES.

(a) TAX PARITY FOR ROLL-YOUR-OWN TOBACCO.—Section 5701(g) of the Internal Revenue Code of 1986 is amended by striking ''$24.78'' and inserting ''$49.56''.

(b) TAX PARITY FOR PIPE TOBACCO.—Section 5701(f) of the Internal Revenue Code of 1986 is amended by striking ''$2.8311 cents'' and inserting ''$49.56''.

(c) TAX PARITY FOR SMOKELESS TOBACCO.—

(1) Section 5701(e) of the Internal Revenue Code of 1986 is amended—

(A) in paragraph (1), by striking ''$1.51'' and inserting ''$26.84'';

(B) in paragraph (2), by striking ''50.33 cents'' and inserting ''$10.74''; and

(C) by adding at the end the following:

''(3) SMOKELESS TOBACCO SOLD IN DISCRETE SINGLE-USE UNITS.—On discrete single-use units, $100.66 per thousand.''.

(2) Section 5702(m) of such Code is amended—

(A) in paragraph (1), by striking ''or chewing tobacco'' and inserting '', chewing tobacco, or discrete single-use unit'';

(B) in paragraphs (2) and (3), by inserting ''that is not a discrete single-use unit'' before the period in each such paragraph; and

(C) by adding at the end the following:

''(4) DISCRETE SINGLE-USE UNIT.—The term 'discrete single-use unit' means any product containing, made from, or derived from tobacco or nicotine that—

''(A) is not intended to be smoked; and

''(B) is in the form of a lozenge, tablet, pill, pouch, dissolvable strip, or other discrete single-use or single-dose unit.''.

(d) TAX PARITY FOR SMALL CIGARS.—Paragraph (1) of section 5701(a) of the Internal Revenue Code of 1986 is amended by striking ''$50.33'' and inserting ''$100.66''.

(e) TAX PARITY FOR LARGE CIGARS.—

(1) IN GENERAL.—Paragraph (2) of section 5701(a) of the Internal Revenue Code of 1986 is amended by striking ''52.75 percent'' and all that follows through the period and inserting the following: ''$49.56 per pound and a proportionate tax at the like rate on all fractional parts of a pound but not less than 10.066 cents per cigar.''.

(2) GUIDANCE.—The Secretary of the Treasury, or the Secretary's delegate, may issue guidance regarding the appropriate method for determining the weight of large cigars for purposes of calculating the applicable tax under section 5701(a)(2) of the Internal Revenue Code of 1986.

(f) TAX PARITY FOR ROLL-YOUR-OWN TOBACCO AND CERTAIN PROCESSED TOBACCO.—Subsection (o) of section 5702 of the Internal Revenue Code of 1986 is amended by inserting '', and includes processed tobacco that is removed for delivery or delivered to a person other than a person with a permit provided under section 5713, but does not include removals of processed tobacco for exportation'' after ''wrappers thereof''.

(g) CLARIFYING TAX RATE FOR OTHER TOBACCO PRODUCTS.—

(1) IN GENERAL.—Section 5701 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(i) OTHER TOBACCO PRODUCTS.—Any product not otherwise described under this section that has been determined to be a tobacco product by the Food and Drug Administration through its authorities under the Family Smoking Prevention and Tobacco Control Act shall be taxed at a level of tax equivalent to the tax rate for cigarettes on an estimated per use basis as determined by the Secretary.''.

(2) ESTABLISHING PER USE BASIS.—For purposes of section 5701(i) of the Internal Revenue Code of 1986, not later than 12 months after the later of the date of the enactment of this Act or the date that a product has been determined to be a tobacco product by the Food and Drug Administration, the Secretary of the Treasury (or the Secretary of the Treasury's delegate) shall issue final regulations establishing the level of tax for such product that is equivalent to the tax rate for cigarettes on an estimated per use basis.

(h) CLARIFYING DEFINITION OF TOBACCO PRODUCTS.—

(1) IN GENERAL.—Subsection (c) of section 5702 of the Internal Revenue Code of 1986 is amended to read as follows:

''(c) TOBACCO PRODUCTS.—The term 'tobacco products' means—

''(1) cigars, cigarettes, smokeless tobacco, pipe tobacco, and roll-your-own tobacco, and

''(2) any other product subject to tax pursuant to section 5701(i).''.

(2) CONFORMING AMENDMENTS.—Subsection (d) of section 5702 of such Code is amended by striking ''cigars, cigarettes, smokeless tobacco, pipe tobacco, or roll-your-own tobacco'' each place it appears and inserting ''tobacco products''.

(i) INCREASING TAX ON CIGARETTES.—

(1) SMALL CIGARETTES.—Section 5701(b)(1) of such Code is amended by striking ''$50.33'' and inserting ''$100.66''.

(2) LARGE CIGARETTES.—Section 5701(b)(2) of such Code is amended by striking ''$105.69'' and inserting ''$211.38''.

(j) TAX RATES ADJUSTED FOR INFLATION.—Section 5701 of such Code, as amended by subsection (g), is amended by adding at the end the following new subsection:

''(j) INFLATION ADJUSTMENT.—

''(1) IN GENERAL.—In the case of any calendar year beginning after 2021, the dollar amounts provided under this chapter shall each be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2020' for 'calendar year 2016' in subparagraph (A)(ii) thereof.

''(2) ROUNDING.—If any amount as adjusted under paragraph (1) is not a multiple of $0.01, such amount shall be rounded to the next highest multiple of $0.01.''.

(k) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On tobacco products manufactured in or imported into the United States which are removed before any tax increase date and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 of such Code on such article.

(2) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) on such date for which such person is liable.

(3) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding tobacco products on any tax increase date to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before the date that is 120 days after the effective date of the tax rate increase.

(4) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (commonly known as the Foreign Trade Zone Act, 48 Stat. 998, 19 U.S.C. 81a et seq.), or any other provision of law, any article which is located in a foreign trade zone on any tax increase date shall be subject to the tax imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of an officer of the United States Customs and Border Protection of the Department of Homeland Security pursuant to the 2d proviso of such section 3(a).

(5) DEFINITIONS.—For purposes of this subsection—

(A) IN GENERAL.—Any term used in this subsection which is also used in section 5702 of such Code shall have the same meaning as such term has in such section.

(B) TAX INCREASE DATE.—The term ''tax increase date'' means the effective date of any increase in any tobacco product excise tax rate pursuant to the amendments made by this section (other than subsection (j) thereof).

(C) SECRETARY.—The term ''Secretary'' means the Secretary of the Treasury or the Secretary's delegate.

(6) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(7) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

(l) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the amendments made by this section shall apply to articles removed (as defined in section 5702(j) of the Internal Revenue Code of 1986) after the last day of the month which includes the date of the enactment of this Act.

(2) DISCRETE SINGLE-USE UNITS AND PROCESSED TOBACCO.—The amendments made by subsections (c)(1)(C), (c)(2), and (f) shall apply to articles removed (as defined in section 5702(j) of the Internal Revenue Code of 1986) after the date that is 6 months after the date of the enactment of this Act.

(3) LARGE CIGARS.—The amendments made by subsection (e) shall apply to articles removed after December 31, 2021.

(4) OTHER TOBACCO PRODUCTS.—The amendments made by subsection (g)(1) shall apply to products removed after the last day of the month which includes the date that the Secretary of the Treasury (or the Secretary of the Treasury's delegate) issues final regulations establishing the level of tax for such product.

By Ms. KLOBUCHAR:

S. 422. A bill to allow Senators, Senators-elect, committees of the Senate, leadership offices, and other offices of the Senate to share employees, and for other purposes; considered and passed.

S. 422

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Senate Shared Employee Act''.

SEC. 2. ALLOWING SENATORS, COMMITTEES, LEADERSHIP OFFICES, AND OTHER OFFICES OF THE SENATE TO SHARE EMPLOYEES.

(a) IN GENERAL.—Section 114 of the Legislative Branch Appropriation Act, 1978 (2 U.S.C. 4576) is amended—

(1) by inserting ''(a)'' before ''Notwithstanding'';

(2) by striking ''position, each of'' and all that follows through the period at the end and inserting the following: ''qualifying position if the aggregate gross pay from those positions does not exceed—

''(1) the maximum rate specified in section 105(d)(2) of the Legislative Branch Appropriation Act, 1968 (2 U.S.C. 4575(d)(2)), as amended and modified; or

''(2) in a case where 1 or more of the individual's qualifying positions are positions described in subsection (d)(2)(B), the maximum rate specified in section 105(e)(3) of the Legislative Branch Appropriation Act, 1968 (2 U.S.C. 4575(e)(3)), as amended and modified.''; and

(3) by adding at the end the following:

''(b)(1) For an individual serving in more than 1 qualifying position under subsection

(a), the cost of any travel for official business shall be paid by the office authorizing the travel.

''(2) Messages for each electronic mail account used in connection with carrying out the official duties of an individual serving in more than 1 qualifying position under subsection (a) may be delivered to and sent from a single handheld communications device provided to the individual for purposes of official business.

''(3)(A) For purposes of the Ethics in Government Act of 1978 (5 U.S.C. App.), the rate of basic pay for an individual serving in more than 1 qualifying position under subsection (a) shall be the total basic pay received by the individual from all such positions.

''(B) For an individual serving in more than one qualifying position under subsection (a), for purposes of the rights and obligations described in, or described in the provisions applied under, title II of the Congressional Accountability Act of 1995 (2 U.S.C. 1311 et seq.) related to practices used at a time when the individual is serving in such a qualifying position with an employing office, the rate of pay for the individual shall be the individual rate of pay received from the employing office.

''(c)(1) If the duties of a qualifying position under subsection (a) include information technology services and support, an individual may only serve in the qualifying position and 1 or more additional qualifying positions under such subsection if the individual is in compliance with each information technology standard and policy established for Senate offices by the Office of the Sergeant at Arms and Doorkeeper of the Senate.

''(2) Notwithstanding subsection (a), an employee serving in a qualifying position in the Office of the Secretary of the Senate or the Office of the Sergeant at Arms and Doorkeeper of the Senate may serve in an additional qualifying position only if—

''(A) the other qualifying position is with the other Office; or

''(B) the Committee on Rules and Administration of the Senate has approved the arrangement.

''(d) In this section, the term 'qualifying position' means a position that—

''(1) is designated as a shared position for purposes of this section by the Senator or other head of the office in which the position is located; and

''(2) is one of the following:

''(A) A position—

''(i) that is in the office of a Senator; and

''(ii) the pay of which is disbursed by the Secretary of the Senate.

''(B) A position—

''(i) that is in any committee of the Senate (including a select or special committee) or a joint committee of Congress; and

''(ii) the pay of which is disbursed by the Secretary of the Senate out of an appropriation under the heading 'INQUIRIES AND INVESTIGATIONS' or 'JOINT ECONOMIC COMMITTEE', or a heading relating to a Joint Congressional Committee on Inaugural Ceremonies.

''(C) A position—

''(i) that is in another office (excluding the Office of the Vice President and the Office of the Chaplain of the Senate); and

''(ii) the pay of which is disbursed by the Secretary of the Senate out of an appropriation under the heading 'SALARIES, OFFICERS AND EMPLOYEES'.

''(D) A position—

''(i) that is filled pursuant to section 105 of the Second Supplemental Appropriations Act, 1978 (2 U.S.C. 6311); and

''(ii) the pay of which is disbursed by the Secretary of the Senate out of an appropriation under the heading 'MISCELLANEOUS ITEMS'.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect beginning on the day that is 6 months after the date of enactment of this Act.

By Mr. DURBIN (for himself, Mr. LEE, Mr. LEAHY, Mr. GRASSLEY, Mrs. FEINSTEIN, Mr. RUBIO, Ms. KLOBUCHAR, Mr. CRUZ, Mr. COONS, Mrs. BLACKBURN, Mr. BLUMENTHAL, and Ms. HIRONO):

S. 426. A bill to amend the Inspector General Act of 1978 relative to the powers of the Department of Justice Inspector General; to the Committee on the Judiciary.

Mr. DURBIN. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 426

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Inspector General Access Act of 2021''.

SEC. 2. INVESTIGATIONS OF DEPARTMENT OF JUSTICE PERSONNEL.

Section 8E of the Inspector General Act of 1978 (5 U.S.C. App.) is amended—

(1) in subsection (b)—

(A) in paragraph (2), by striking ''and paragraph (3)'';

(B) by striking paragraph (3);

(C) by redesignating paragraphs (4) and (5) as paragraphs (3) and (4), respectively; and

(D) in paragraph (4), as redesignated, by striking ''paragraph (4)'' and inserting ''paragraph (3)''; and

(2) in subsection (d), by striking '', except with respect to allegations described in subsection (b)(3),''.

By Ms. COLLINS (for herself and Ms. ROSEN):

S. 436. A bill to provide Federal matching funding for State-level broadband programs; to the Committee on Commerce, Science, and Transportation.

Ms. COLLINS. Mr. President, I rise today to introduce the American Broadband Buildout Act. This legislation would help ensure that rural Americans have access to broadband services at the speeds they need to participate fully in the benefits of our modern society and economy. I want to thank my colleague Senator ROSEN for joining me in introducing this bill today.

Twenty-five years ago, Americans typically accessed the internet using their home phone lines via modems, capable of downloading data at just 56 kilobits per second, too slow even to support MP3-quality streaming music. Today, the Federal Communications Commission defines broadband service as having a threshold download speed nearly 500 times faster.

Many areas of our country, particularly our rural communities, simply do not have the infrastructure to achieve these speeds and fully tap into the opportunities that digital connectivity can deliver. According to a 2019 Pew Research Center survey, nearly 37 percent of rural Americans lack a broadband connection compared to 25 percent of urban Americans.

Similar disparities occur in terms of broadband adoption. That is the rate at which Americans subscribe to broadband service once they have access to it.

The survey also found that 15 percent of rural Americans don't use the internet at home compared to just 9 percent of urban Americans.

The current pandemic has brought these connectivity challenges into stark focus as many families have had to move their education, their workplaces, and their healthcare services online.

Andrea Powers, the town manager of Fort Fairfield in northern Maine, recently described a number of challenges in her community: students who have to sit on the town's library steps in order to finish research projects and submit their papers; a business owner who was forced to relocate his company to another community in order to have a chance to succeed; a senior citizen who requires the care of distant doctors but does not have the capacity to travel nor access the telehealth options.

Andrea told me the story of one family whose jobs rely heavily on access to high-speed broadband. They were told that it would cost them $15,000 to bring that connection to their doorstep. Andrea summed up the reality facing so many rural communities that lack access in this way. She said: ''We will continue to see a loss of business retention and expansion along with job creation. We simply cannot afford to allow this to happen. Online schooling, business growth and development, telehealth care, and economic agriculture success are all dependent on . . . affordable fiber optic broadband.''

Telehealth services are an essential piece of the national broadband conversation. Often, rural communities struggle to attract and retain healthcare providers that they need to ensure access to quality care. Broadband is vital to bridging that gap to enable innovative healthcare delivery.

Let me give you an example. Hospice workers at Northern Light Homecare were able to use the internet and video technology to help support a patient living on an island off the coast of Maine—not far as the seagull flies, but hours away in travel time. Although the connection was poor, the video enabled nurses to monitor the patient's condition and symptoms and, equally important, to provide emotional support to her and to her family. As one hospice worker put it, ''our hospice team could be doing so much more with video and telemonitoring technologies if only Maine had better connectivity.''

The American Broadband Buildout Act would help close this ''digital divide'' between urban and rural America by providing up to $15 billion in matching grants to assist States and State-

approved entities in building that ''last-mile'' infrastructure to bring high-speed broadband directly to homes and businesses in areas that lack it.

Projects would have to be located in unserved areas—that is, areas where broadband is unavailable at speeds that meet the FCC standards. Focusing on those areas will direct support where it is most needed and will protect against overbuilding where infrastructure is already in place.

The Federal funding authorized in our bill would be matched through public-private partnerships between the broadband service provider and the State where they provide service. This means that States and their private sector partners will have ''skin in the game'' so that the projects will be well thought out and sustainable. This model will also incentivize existing service providers to extend their networks to rural areas and swiftly connect new households.

Third, the bill would require that projects be designed to be ''future proof,'' meaning that the infrastructure installed must be capable of delivering higher speeds as broadband accelerates in the future. We want these investments to serve rural Americans now and in the future without having to rebuild every time technology advances.

Our bill would also prioritize projects in States that have traditionally lagged behind the national average in terms of broadband subscribers and those that are at risk of falling further behind as broadband speeds increase.

Finally, the bill would provide grants for digital literacy and public awareness campaigns to encourage wider broadband adoption once access is available. Increasing broadband adoption will help drive down the cost of the service and make it more affordable for everyone.

Rural Americans need access to high-speed internet just as urban Americans do. In fact, one could argue they need it even more, especially during these times that can require remote work, education, and healthcare. The bill that Senator ROSEN and I are introducing today would help bridge this digital divide by funding ''future proof'' broadband where it is needed most and give a boost to job creation in rural America.

As the Presiding Officer well knows, businesses will not locate in areas that do not have this essential service, in many cases. I urge all of our colleagues to join in supporting this bill.

Thank you.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 71—EXPRESSING THE SENSE OF THE SENATE THAT ALIENS CONVICTED OF DRUNK DRIVING OFFENSES QUALIFY AS A PUBLIC SAFETY THREAT FOR THE PURPOSES OF IMMIGRATION ENFORCEMENT

Ms. ERNST (for herself, Mr. GRASSLEY, and Mrs. FISCHER) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 71

Whereas Sarah Root of Council Bluffs, Iowa, died at the hands of a drunk driver who was not lawfully present in the United States;

Whereas the mission of the immigration enforcement process is to ensure the safety of our communities; and

Whereas drunk driving and aliens convicted of drunk driving are a threat to public safety of the United States, and to say otherwise is offensive to both the victims of drunk driving offenses and those who seek to enforce criminal statutes related to drunk driving: Now, therefore, be it

Resolved, That it is the sense of the Senate that any guidance issued by the Department of Homeland Security or U.S. Immigration and Customs Enforcement as it relates to immigration enforcement and removal of aliens should not deprioritize the removal of aliens convicted of—

(1) drunk driving or otherwise driving under the influence; or

(2) any crime which includes as an element an act of assault or violence.

SENATE RESOLUTION 72—OPPOSING THE LIFTING OF SANCTIONS IMPOSED WITH RESPECT TO IRAN WITHOUT ADDRESSING THE FULL SCOPE OF IRAN'S MALIGN ACTIVITIES, INCLUDING ITS NUCLEAR PROGRAM, BALLISTIC AND CRUISE MISSILE CAPABILITIES, WEAPONS PROLIFERATION, SUPPORT FOR TERRORISM, HOSTAGE-TAKING, GROSS HUMAN RIGHTS VIOLATIONS, AND OTHER DESTABILIZING ACTIVITIES

Mr. COTTON (for himself, Mr. CRUZ, Mr. RUBIO, Mr. CORNYN, Mr. HAWLEY, Mr. CRAMER, Mr. TILLIS, Mr. BOOZMAN, Mrs. HYDE-SMITH, Mr. SASSE, Mr. MARSHALL, Mr. DAINES, Mr. ROUNDS, Mr. YOUNG, Mr. BARRASSO, Mrs. BLACKBURN, Mr. SULLIVAN, Mr. TUBERVILLE, Mr. BLUNT, Mr. THUNE, Ms. LUMMIS, Mr. INHOFE, Mr. HOEVEN, Mr. HAGERTY, Mr. LANKFORD, and Mr. CRAPO) submitted the following resolution; which was referred to the Committee on Banking, Housing, and Urban Affairs:

S. RES. 72

Whereas the Joint Comprehensive Plan of Action (commonly referred to as the ''JCPOA''), an agreement that was finalized by the administration of President Barack Obama and the governments of the United Kingdom, Germany, France, the People's Republic of China, and the Russian Federation in July 2015, provided Iran permanent sanctions relief and access to more than $100,000,000,000 in return for temporary restrictive measures on Iran's nuclear program;

Whereas, under the JCPOA, restrictions on the number and types of centrifuges that Iran may manufacture, retain, test, and use, the number and types of enrichment facilities that Iran may construct, and the amount and level of enriched uranium and heavy water that Iran may stockpile, will expire;

Whereas multiple United Nations Security Council resolutions adopted between 2006 and 2010 required Iran to suspend all enrichment of uranium, but the JCPOA did not require Iran to cease its enrichment of uranium, a failure that is directly responsible for Iran's expanded enrichment activity today;

Whereas United Nations Security Council Resolution 2231 (in this preamble referred to as ''UNSCR 2231''), adopted on July 20, 2015, called on Iran not to undertake any activity related to nuclear-capable ballistic missile activities for 8 years and imposed a 5-year ban on conventional arms transfers to and from Iran;

Whereas neither the JCPOA nor UNSCR 2231 adequately addressed the threat emanating from Iran's ballistic and cruise missile program or long-standing support for terrorism, and the sunset provisions applied to prohibitions in UNSCR 2231 and the JCPOA severely weakened their restrictions and inadvertently legitimized that program and support;

Whereas, based on the shortcomings of the JCPOA and UNSCR 2231, bipartisan majorities in both the Senate and the House of Representatives opposed the JCPOA and the sanctions relief for Iran contained in the agreement;

Whereas the sanctions relief contained in the JCPOA provided resources necessary for Iran to continue developing ballistic missiles and supporting terrorism;

Whereas the United States Government has designated Iran's Islamic Revolutionary Guard Corps (in this preamble referred to as the ''IRGC'') as a foreign terrorist organization under section 219(a) of the Immigration and Nationality Act (8 U.S.C. 1189(a)) and a specially designated global terrorist entity pursuant to Executive Order 13224 (50 U.S.C. 1701 note; relating to blocking property and prohibiting transactions with persons who commit, threaten to commit, or support terrorism);

Whereas, by a vote of 98–2 in the Senate and 419–3 in the House of Representatives, Congress required the imposition of terrorism-related sanctions against the IRGC as part of the Countering America's Adversaries Through Sanctions Act (22 U.S.C. 9401 et seq.);

Whereas, on May 21, 2018, the United States Government outlined steps that the Government of Iran must take to normalize relations with the United States, including—

(1) providing the International Atomic Energy Agency a full account of the possible military dimensions of its nuclear program and permanently and verifiably abandoning that program;

(2) ceasing all enrichment and vowing never to pursue plutonium reprocessing;

(3) providing the International Atomic Energy Agency with access to all sites throughout the entire country;

(4) ending its development and proliferation of ballistic missiles;

(5) releasing all United States citizens currently held hostage, as well as citizens of countries that are partners and allies of the United States;

(6) ending support for terrorist groups, including Hezbollah, Hamas, and the Palestinian Islamic Jihad;